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ANG YEW MENG & ANOR

v.

DR SASHIKANNAN ARUNASALAM & ORS

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HIGH COURT MALAYA, JOHOR BAHRU
SUPANG LIAN JC
[CIVIL SUIT NO: 22-466-2003]
23 MARCH 2011

C ***TORT:*** *Negligence - Medical negligence - Whether there was duty of care - Whether defendant held himself out as possessing special skill and knowledge*

D ***TORT:*** *Negligence - Medical negligence - Whether there was breach of duty - Standard of care to be applied - Application of test in Rogers v. Whitaker - Whether lack of registration of defendant as medical practitioner a factor to be considered - Whether treatment by first defendant appropriate and in accordance with standard of care*

E ***TORT:*** *Negligence - Vicarious liability - Medical negligence - Whether conduct of first defendant could be attributed to second and third defendants - Whether first defendant employee of second and third defendants*

F ***CONTRACT:*** *Formation - Whether contract formed between plaintiff and defendant - Whether there was consideration - Whether there was intention to create contract - Whether defendant had authority to enter into contract*

G The first and second plaintiffs are husband and wife. Their son who developed a fever was brought to Poliklinik Taj (the third defendant), at 5pm on 1 December 2001, where the first defendant was on duty. The plaintiffs' son was given voltaren *vide* injection by the first defendant after which the second plaintiff was asked to take her son to the hospital. On arrival at the hospital at about 5.40pm, the plaintiffs' son was pronounced dead. It was undisputed that the plaintiffs' son had been feeling unwell since noon that day. According to the forensic pathologist, the cause of death was myocarditis brought about by an infection that was believed to be viral in nature. The other children of the plaintiffs were also ill but had recovered after responding to treatment. At the time in question, the first defendant was undergoing internship

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as well as doing attachment with the second defendant. The first defendant was conferred the degree of MBSS on 20 February 2002 and on 27 February 2002, he was provisionally registered under s. 12(1) of the Medical Act 1971. The plaintiffs brought this action for damages against the defendants contending that the death of their son was caused by negligence of the defendants and/or breach of contractual duty. The issues for consideration were as follows, namely: (a) whether there was a duty of care; (b) whether there was a breach of that duty of care; and (c) whether there was, alternatively, breach of contract.

Held (dismissing the plaintiff's claim):

(1) The essential components of the modern tort of negligence as recognised, are three, namely: (a) the existence of a duty to take care, which is owed by the defendant to the complainant; (b) the failure to attain the standard of care, prescribed by the law, thereby committing a breach of such duty; and (c) damage, which is both causally connected with such breach and recognised by the law, has been suffered by the complainant. If the claimant satisfies the court on the evidence that these three ingredients are made out, the defendant should be held liable in negligence. (para 25)

(2) If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. In this case, the first defendant had chosen to act and embarked upon the task of treating the child thereby coming to its aid. He was not obliged to do so, but in coming to the aid of the child, he had entered voluntarily into a relation of responsibility and hence assuming a duty. He was therefore liable for any failure to use reasonable care in dealing with the child until the emergency has ended. (paras 28 & 37)

(3) The first defendant, being merely an attachment student under strict instructions not to treat any patient, was never an employee or a staff of the clinic. Moreover, there was no evidence that the second and third defendants had ever held him out to be a doctor or staff employed by the clinic. That being so, there was no question of the clinic being vicariously

liable for the negligence, if any, of the first defendant in meting out treatment. Hence, the second and third defendants owed the plaintiffs no duty of care in the first place. (para 38)

(4) The test in *Rogers v. Whitaker* is that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that skill. The test dictates that the court, and not the medical profession, must decide on the liability of doctors who are defendants in medical negligence actions. In so deciding, the courts are at liberty to reject medical expert evidence which does not really stand up to logical analysis, but instead must scrutinise and evaluate the relevant evidence in order to adjudicate on the appropriate standard of care. Due regard must be had to the relevancy of the opinion of experts. (para 40)

(5) According to the evidence provided by the expert, the treatment that the first defendant provided to the deceased child was appropriate and in accordance with the standard of care required of a medical doctor in the circumstances of the case. This remained true whether the first defendant was registered as a medical practitioner or not. (para 65)

(6) The fact of registration would not have made a more skilled or competent a person out of the first defendant in the field of medicine. Conversely, the lack of it would not have made him any less skilled or competent in his training. The first defendant had completed medical school and had passed his medical degree examinations and was undergoing internship at the government hospital. The first defendant also received provisional registration under the Medical Act 1971 and therefore was qualified as a medical doctor. Thus, the first defendant was possessed of a special skill or competence. (para 43)

(7) On the issue of breach of contract, there was no contract formed between the plaintiffs and the defendants as, *inter alia*, there was no consideration provided by the plaintiffs nor was any consideration accepted by the first defendant, there was no intention to create a contractual relationship on the part of the defendants and the first defendant had no authority

whether actual or ostensible, to enter into a contract with the plaintiffs on behalf of the second and third defendants. Even if it could be said that a contract was formed, it had not been proven that there was any breach of contract or any loss caused to the plaintiffs by the defendants. This was based on the fact that the emergency medical treatment and the procedures that were followed did not cause the death of the deceased nor worsen his condition. (paras 92-97)

Case(s) referred to:

Barkway v. South Wales Transport Co Ltd [1950] 1 All ER 392 ***(refd)***
Barnett v. Chelsea and Kensington Hospital Management Committee [1969] 1 QB 428 ***(refd)***
Bolam v. Friern Hospital Management Committee [1957] 2 All ER 118 ***(not foll)***
Chai Yee Chong v. Lew Thai [2004] 2 CLJ 321 CA ***(refd)***
Chien Tham Kong v. Excellent Strategy Sdn Bhd & 2 Ors [2008] 1 LNS 411 HC ***(foll)***
Cork v. Kirby Maclean Ltd [1952] 2 All ER 402 ***(refd)***
Foo Fio Na v Dr Soo Fook Mun & Anor [2007] 1 CLJ 229 FC ***(foll)***
Hasan Datolah v. Kerajaan Malaysia [2010] 5 CLJ 764 CA ***(foll)***
Joginder Kaur & Anor v. Malayan Banking Ltd & Anor [1970] 1 LNS 41 FC ***(refd)***
Mathews v. McLaren, Jones and The Ogopogo Horsley and Others [1969] 1 Lloyd's Rep 374 ***(refd)***
Nettleship v. Weston [1971] 2 QB 691 ***(foll)***
Payremalu Veerappan v. Dr Amarjeet Kaur & Ors [2001] 4 CLJ 380 HC ***(refd)***
Pickford v. Imperial Chemical Industries plc [1998] 3 All ER 46 ***(refd)***
Poonam Verma v. Ashwin Patel & Ors AIR 1996 SC 2111 ***(refd)***
R v. Bateman [1925] 94 LJKB 791 ***(foll)***
Rogers v. Whitaker [1992] 175 CLR 479 ***(foll)***
Scott v. London and St Katherine Docks Co (1865) 3 H & C 596 ***(refd)***
Siti Rohani Mohd Shah & Ors v. Hj Zainal Hj Saifiee & Anor [2001] 1 CLJ 498 HC ***(refd)***
Sundram Ramasay v. Arujunan Arumugam & Anor [1994] 4 CLJ 300 SC ***(refd)***
Wu Siew Ying v. Gunung Tunggal Quarry & Construction Sdn Bhd & Ors [1999] 4 CLJ 339 HC ***(refd)***

Legislation referred to:

Contracts Act 1950, s. 26(b)
Evidence Act 1950, s. 31
Medical Act 1971, ss. 12(1)(a)(i), (ii), 14

Other source(s) referred to:
Charlesworth & Percy on Negligence, 10th edn, 2001, paras 2-68, 2-69, 6-45, 6-46, 8-131
Clerk & Lindsell on Torts, 18th edn, 2000, paras 2-06, 7-192

For the plaintiffs - TS Chang; M/s Henry Soon & Chang
For the 1st defendant - RK Menon; M/s RK Menon & Co
For the 2nd & 3rd defendants - S Subayogan; M/s Suba & Co

Reported by EM Goh

JUDGMENT

Supang Lian JC:

The Documentary Evidence And Exhibits

[1] For the sake of clarity, I will first introduce the documentary evidence and exhibits tendered. The agreed bundle of documents are as follows:

(1) Bundle B	:	documents therein agreed on authenticity and content (Part A)
(2) Bundle C	:	documents therein agreed on authenticity (Part B)
(3) Bundle D	:	documents therein to be formally proved (Part C)
(4) Exhibit P1	:	document at p. 1 of bundle D but agreed at the trial
(5) Exhibit P1(a)	:	document at p. 2 of bundle D but agreed at the trial
(6) Exhibits D1, D2 and D3	:	documents agreed at the trial
(7) Exhibit D4	:	document agreed at the trial
(8) Exhibit D5	:	document agreed at the trial

Hereinafter, the documents will be referred to either by the exhibit number or the bundle marking and page as for instance, p. 1 of bundle B will be referred to as B1 and p. 3 of bundle C as C3 and so on.

The Facts

[2] The 1st plaintiff Mr Ang Yew Meng and the 2nd plaintiff Madam Siah Kwee Khim are husband and wife. They had several children one of which was a son by the name of Ang Wee Siang. On the evening of 1 December 2001 at about 5pm, Madam Siah showed up at the Poliklinik Taj 24 Jam ('the clinic') located at No. 27, Jalan Sri Perkasa 2/1, Taman Tampoi Utama in Johor Bahru. She was in a state of panic, distress and agitation. At that time Dr Sashikannan Arunasalam, the 1st defendant, was in the clinic. He was alone. Madam Siah told him that her son was in her car parked outside with high fever and she asked him for help. He told her that the doctor was out. She nevertheless insisted that he helped. He went over to the car and found a young boy lying supine on the rear seat seemingly unconscious and with a high temperature. The boy had no control of his limbs. The 1st defendant realised at once that his condition was serious and life threatening. He asked the mother to take him to the hospital but she entreated him to examine and treat the boy. He relented. He said he could not turn her away because it was an emergency and with the knowledge that he had, he thought he should render assistance that might help. Thereupon, he carried the child into the clinic and placed him on the examination bed. As he was carrying the boy, he tried to get the history of the illness from the mother. However, there was a language barrier as she could not understand him and at the same time, she was upset, frightened and slightly incoherent. Other than the child's name and age, he could not get any useful information from her on the condition of the child.

[3] The 1st defendant took the child's temperature and found it to be 40°C. He did not take the child's blood pressure because he thought there was no paediatric cuff in the clinic. Dr Muruga Raj, the 2nd defendant and the doctor in charge at the clinic, was later to testify that the paediatric cuff was on the doctor's table, which the 1st defendant had no access to. Seeing the serious condition of the child, the 1st defendant thought it best for the mother to rush him to a hospital as the clinic had limited facilities to treat a patient in that condition. The mother however implored him to treat the child. He started cold water sponging to try to bring down the temperature. That did not work. He therefore decided to use Diclofenac Sodium also known as Voltaren. Before

A he administered it, he asked the mother for any history of allergic reaction to the drug. She was still confused and incoherent. Being unable to find any Diclofenac Sodium suppositories, the 1st defendant administered 1.5ml of Diclofenac Sodium in solution *vide* injection intramuscularly. The 2nd plaintiff claimed at the trial that
B she did not consent to the injection being given to the child. This is because from her experience, the rectal suppository is normally used to bring down high fever in children and not by injection. I did not believe her when she said that she had objected to the injection. In the first place, as she conceded in court, she was
C desperate for the 1st defendant to treat the child. I doubt very much she was in the frame of mind to object to the treatment given. Furthermore, no such objection was ever stated either in the contemporaneous police report (C1) of the 1st plaintiff lodged on the day of the incident or in his second police report (C3)
D lodged on 11 October 2002. This is even though the fact of an injection being given is stated in both reports. As well, the plaintiffs in their statement of claim (SOC) filed on 8 August 2003 had never asserted that the injection was given over the objections of the 2nd plaintiff. This allegation surfaced for the first
E time in the plaintiffs' witness statements during preparations for the trial. In such circumstances, I was convinced it was an afterthought on the part of the plaintiffs and ought to be rejected. That I did.

F **[4]** The 1st defendant testified that thereafter, he asked the 2nd plaintiff to take the boy immediately to a hospital as he had done all he could. He did not call an ambulance at that point in time because he thought it best for the child to get to the hospital as soon as possible rather than waste precious time waiting for one.
G The 2nd plaintiff disputed this saying that he had instead told her the child's condition was not serious and to take him home to rest. I did not believe the 2nd plaintiff on this. It was inherently improbable that the 1st defendant would have said to her that the child's condition was not serious enough to warrant going to the
H hospital given that the child was brought to the clinic in an unconsciousness state and with high temperature. That the child had arrived unconscious and with high temperature is a fact conceded by the plaintiffs. Besides, the 2nd plaintiff herself admitted that after treatment, she wanted the 1st defendant to
I take the child to the Johor Specialist Hospital. This is consistent with the evidence of the 1st defendant that he had asked her to go to a hospital.

[5] Now, the 1st defendant denied that the 2nd plaintiff had made a request of him to send the child to hospital. I did not accept the 1st defendant's denial of this because it is contrary to the admission he made in his pleading. By para. 12 of his statement of defence, the 1st defendant admitted that the 2nd plaintiff had made such a request which he had declined. Parties are bound by their pleadings. Furthermore, the 1st defendant had not explained this contrary position he took in court, hence, by virtue of s. 31 of the Evidence Act 1950 this specific admission in his statement of defence operates as an estoppel against him.

[6] Although declining to send them to the hospital, the 1st defendant helped to carry the child back to the car and placed him in the back seat. The child was still unconscious. According to the 1st defendant the child was at the clinic for approximately ten minutes. The plaintiffs on the other hand asserted that the child was at the clinic for half an hour or slightly more. I will say more on this.

[7] The 2nd plaintiff then drove off heading for the Johor Specialist Hospital ('the hospital'). It was raining heavily and traffic was heavy. After five to ten minutes, she observed that her son's face and lips had turned blue and froth came out from the mouth. As a result, she became more panicky and drove whilst keeping an eye on the boy. About 0.5km from the hospital, her car skidded. Some members of the public kindly rendered assistance sending her and her son to the hospital. Upon arrival at the entrance of the Accident & Emergency ward of the hospital, the 2nd plaintiff observed that her son had ceased breathing ('sesak nafas') and vomited coffee-coloured substance. Having said that, the 2nd plaintiff under cross-examination stated that she was not sure whether at that point in time her son was still breathing or had difficulty breathing. Whatever might have been the case, what followed was that the child was put on a trolley and brought into the Accident & Emergency ward. The exact time of arrival of the child in the A & E ward is 5.40pm as recorded by Dr Alex Tang Tuck Hon in the medical report (at C4). It is stated in the same report, and this was never disputed or contradicted, that Dr Yoga, the Medical Officer on call, immediately examined the child upon admission. Sadly, he found the child to be already dead. The 2nd plaintiff too testified that the doctor on duty at the ward told her that her son had expired at 5.40pm. I therefore found on the

A evidence adduced that the child had expired soon after arrival at the entrance of the A & E ward and immediately before admission in the A & E ward at 5.40pm.

[8] The 2nd plaintiff under cross-examination stated that it had
B taken her half an hour to get from the clinic to the hospital. This is significant given that the plaintiffs had asserted during submissions that the 1st defendant took an hour or more to treat the child at the clinic. I could not accept the plaintiffs' contention that the 1st defendant took that long to treat the child. To start
C with, from the pleadings and the evidence of the witnesses, there is no dispute that the 2nd plaintiff and the deceased child had arrived at the clinic at about 5pm. There was also no dispute or challenge to the statement of Dr Alex Tang in C4 that the child was brought into the A & E ward of the hospital at 5.40pm.
D Given that it is the 2nd plaintiff's evidence that she took half an hour to get to the hospital from the clinic, it would follow that their time spent at the clinic could only have been ten minutes or even less. For that reason, I found it established on balance of probabilities that the 2nd plaintiff and the child were at the clinic
E at the most, only for ten minutes.

[9] The 1st plaintiff found out about the death of his son after getting to the hospital at the request of the 2nd plaintiff who had texted him. After consulting with relatives and friends, he went to
F the Poliklinik Taj 24 Jam (the clinic) where he met the 1st defendant. The 1st plaintiff requested to pay for the treatment given earlier to the child. He confessed in court that his intention was to seek evidence. The 1st defendant, not knowing that the child had died, inquired after him. The 1st plaintiff told him that
G his son had recovered. Thereupon, the 1st plaintiff paid RM20 and a receipt was issued. Later at 10.15pm, the 1st defendant went to the Larkin Police Station to lodge a report (C1) on the death of his son. For reasons he did not disclose, the 1st plaintiff in his police report claimed that he, instead of the 2nd plaintiff,
H had brought the deceased child to the clinic. He claimed too that it was he that had seen the 1st defendant giving the Voltaren injection and then rushing to the hospital only to be told upon arrival that the child had passed away.

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[10] It transpired too that some time in the evening of the same day the 1st plaintiff had brought another of his children by the name of Ang Yee Weon to the same hospital. According to Dr Wong Teck Kim in his report (D4), the child had a day history of epigastric pain, vomiting and diarrhea. The next day of 2 December 2001, four more of the children of the plaintiffs were admitted at the hospital. All five children were eventually diagnosed with typhoid and hospitalised for approximately five days. The age of the children ranged from three to ten years. They responded well to treatment, recovered and were discharged.

[11] This brings us to how the 2nd plaintiff and the child had ended up at the clinic that day. Both plaintiffs testified that the deceased, who was eight years going on nine, was well on the morning of 1 December 2001 having been on the computer after waking up. The 2nd plaintiff under cross-examination let on that at noon the deceased suffered from giddiness, had headache and high fever and was vomiting. She gave him chrysanthemum tea. The 1st plaintiff came back from work at 3pm and he too observed that the deceased was weak and his body warm. He left to go jogging shortly after but before he went, he told his wife to bring the child to see a doctor to avoid the infection spreading to the other children. Nonetheless, he claimed it was just normal fever. The 2nd plaintiff however did not send the child immediately to the hospital but waited until as described above, she turned up at the clinic with the child at about 5pm. By that time the child had become unconscious and running a high temperature of 40°C.

[12] Something also needs to be said as to how it was that the 1st defendant was alone at the clinic that day. In December of 2001, he was undergoing internship at the Sultanah Aminah Hospital, Johor Bahru, as well as doing an attachment with the 2nd defendant at the clinic. Under the attachment, the 1st defendant was paid an allowance of RM400-RM450 a month on a pro-rated basis depending on how many days he attended. He did not have authority to treat any patient and was only present for learning purposes when the 2nd defendant or another registered doctor of the clinic was seeing a patient. He was alone for a brief period at the clinic that day because the 2nd defendant who was on duty had gone out for a tea break. The nurse had also gone out for tea break. The 2nd defendant had advised the 1st defendant not to treat any one and he was to inform any

patient that came that the doctor was out. So it was that when the 2nd defendant walked into the clinic at about 5pm she found only the 1st defendant there. The 1st defendant had passed his final MBSS examinations in November/December of 2000 conducted by the Manipal Academy of Higher Education, India and was conferred the degree of MBBS by the same university on 20 February 2002. On 27 February 2002 he was provisionally registered under s. 12(1)(a)(i) and (ii) of the Malaysian Medical Act 1971. He has since been given full registration under s. 14 of the Act.

Cause Of Death

[13] Dr Shahidan bin Md Noor (PW4) was the forensic pathologist that conducted the post mortem of the deceased on 3 December 2001. His medical report is at C34-37. He attributed death to myocarditis brought about by an infection that he believed to be viral in nature.

[14] The defendants called Emeritus Professor Datuk Dr Alexius Ernald Delilkan (DW1) of the Anaesthesiology and Critical Care, University of Malaya to testify as their expert witness. He was of the opinion that death was caused by sepsis (acute septicaemic shock) brought about by an infection in the blood. DW1 noted that although myocarditis, which he said is inflammation of the heart tissues, was present, he was of the opinion that it was brought about by the infection. The findings in Dr Shahidan's report that were relevant to him forming an opinion of sepsis were as follows:

(a) headache, fits and fever suffered by the deceased on the morning of 1 December 2001 before he was treated at the clinic;

(b) swelling in the brain with reactive gliosis detected;

(c) high body temperature of 40°C;

(d) petechiae on liver, heart and other organs;

(e) black coloured fluid in the stomach;

(f) presence of oliguria (no urine being produced); and

(g) presence of lymphocytes on the heart.

[15] DW1 explained that the presence of lymphocytes on the heart, the symptom of fitting, headache and fever that Dr Shahidan noted had manifested earlier in the day of 1 December 2001 suggested that sepsis was present for some duration. On the frothing at the mouth, it was caused by the pulmonary oedema of the lungs, which means swelling and fluid in the lungs brought about by the infection and manifested outwardly as frothing. As for the presence of black or coffee-colored fluid in the stomach and vomited out, it indicates there had been bleeding in the stomach for sometime already. Bleeding tendency, he said, could present in septicaemia.

[16] Although PW4 in his report stated that the infection was likely viral in origin, under cross-examination, PW4 after being apprised of the fact that five siblings of the deceased had been diagnosed and treated for typhoid soon after the death of the deceased, conceded that most of his findings at the autopsy would also fit symptoms of typhoid. He said that with the knowledge that the other siblings had contacted typhoid, it suggested that the deceased might have suffered the same ailment.

[17] DW1 was equally of the opinion that typhoid was probably the infection that led to the septicaemia. His reasons for saying so are these. Firstly, the five young siblings of the deceased that were treated for typhoid soon after the death of the child were later confirmed as typhoid patients. Typhoid is an infectious disease and its characteristics well known. Secondly, in children, typhoid can be a typical and can present with pneumonia. The deceased had symptoms of pneumonia as discovered by Dr Shahidan ie, copious froth and the lungs congested (pulmonary odema). Thirdly, there was also the presence of lymphocytes in the heart as discovered by Dr Shahidan. Lymphocytes he said is a feature of the endotoxic effect of the typhoid organism ie, to say, when the infection is caused by gram negative organism of which typhoid is one, the total white blood count goes down whilst the count of lymphocytes go up. Finally, DW1 was of the view that the symptoms suffered by the deceased and the findings of Dr Shahidan all point to the quick acting fulminant manifestation of typhoid. He explained that there are two types of manifestation of typhoid. One is the slow insidious building up in the system where the patient has fever, weakness and is generally

not well in the first week. On to the 2nd week, it starts picking out organs like the spleen, the heart, the lungs and the brain and the toxic effects of the organism are now on these organs and the gut. The organism in the gut causes a slow build up of enteric fever and diarrhea develops. On the brain, the person might get persistent headache, fitting and even convulsions. On the heart, the person will get the effect of blood pressure falling and heart pump failure, which is myocarditis. The second presentation of the disease can be described as fulminant, that is to say, more acute and fast developing. It moves rapidly within 24 hours, all the symptoms crammed into a short period. This pattern is a typical and manifest in children more than adults and brings on septicaemic shock quickly. DW1 concluded that in this case, the deceased child presented the quick acting fulminant pattern that brought about the acute septicaemic shock causing death.

[18] Thus, on the expert medical evidence of PW4 and DW1, the cause of death was myocarditis brought about by acute septicaemic shock (sepsis) from an infection that was likely typhoid.

[19] The plaintiffs in their statement of claim (SOC) alleged that death was caused by adverse reaction to the Diclofenac Sodium administered by the 1st defendant. I did not find that proven on balance of probabilities. The reasons for saying so are these. Dr Alexius Delilkan did not find any physical evidence of it and Dr Shahidan agreed that there was no evidence of allergic or adverse reaction to drugs administered to the deceased. The plaintiffs did not adduce evidence or call any medical expert to counter their evidence. Furthermore, the evidence is clear that by the time the deceased child presented at the clinic at 5pm that day, he had already suffered symptoms brought about by sepsis. In the first place, the child was clearly brought to the clinic in an unconscious state. In this regard, I found the 2nd defendant's denial of this inexplicable considering that she arrived at the clinic in a state of panic and distress and pleading for help. This in my opinion was an indication of the critical and dire condition of her son. Moreover, the child had to be carried into the clinic from the car. Given the state the 2nd plaintiff was in, the child needing to be carried into the clinic and the undisputed evidence that he was running a temperature of 40°C, I had no difficulty in accepting the evidence of the 1st defendant that the child was unconscious

when he first saw him in the back seat of the car. In any event, counsel for the plaintiffs in his submission conceded that the child was brought to the clinic in an unconscious state. The undisputed evidence of DW1 is that fitting or losing consciousness is a symptom of the toxic effect of the typhoid organism on the brain.

[20] Another indication that sepsis had already set in was the symptoms of giddiness, headache, vomiting and high fever that the child suffered from at noon that day. This was disclosed by the 2nd plaintiff under cross-examination. As well, the 1st plaintiff had observed at 3pm that day that the child was weak and his body warm. He must have thought his condition serious enough for him to tell his wife to bring him to see the doctor. According to Dr Delilkan, and this was supported by the evidence of Dr Shahidan, fits, headache and high body temperature are all indications of an infection or sepsis.

[21] Yet another indication that sepsis had set in was that the child, as testified to by the 2nd plaintiff, vomited out coffee-coloured fluid as they arrived at the entrance of the A & E ward of the hospital. This was only minutes before the child was pronounced dead at 5.40pm. According to both Dr Shahidan and Dr Alex Delilkan, the presence of black or coffee-colored fluid in the stomach is an indication of internal bleeding in the stomach. Dr Alex Delilkan said that bleeding tendency could present in septicaemia and in the stomach, it would take about 12 to 24 hours for the colour of fresh bleeding which is bright red to change to darker colour towards black. That being the case, backtracking would take us to 5.40am of 1 December 2001 as the latest time for the onset of the bleeding and 5.40pm of 30 November 2001 at the earliest. Either way, by the time the deceased was brought to the clinic at about 5pm on 1 December 2001, sepsis had been present in the blood for some duration.

[22] Other than the vomiting of the black liquid, the 2nd plaintiff, as already mentioned, had also observed five to ten minutes into their journey from the clinic to the hospital that the child's face and lips had turned blue and froth came out from the mouth. As explained by Dr Delilkan these symptoms were not associated with allergic reaction to Diclofenac Sodium but rather to heart pump failure brought about by the failure of the heart muscle that had been harmed by the toxic effect of the infection by the typhoid

A organism. As it turned out, all the symptoms that had manifested and had been observed by the 2nd plaintiff as she drove her son to the hospital from the clinic after the injection of Voltaren were due to sepsis that had been present for sometime and not from an allergic reaction to Voltaren. Further, both Dr Shahidan and
B Dr Delilkan attributed the finding during autopsy of diffused infiltration of lymphocytes in the heart to an infection. In addition, Dr Delilkan attributed the finding of petechiae on the liver and heart to sepsis. Given the clear evidence of Dr Shahidan and Dr Delilkan, it became clear to me that there was no evidence of
C any adverse reaction to Diclofenac Sodium.

[23] Instead, what emerged from the evidence of Dr Alexius Delilkan supported by that of Dr Shahidan's and the surrounding circumstances was that the untimely demise of this child was
D caused by acute septaecemic shock from an infection in the blood stream, which in all probability was typhoid that resulted in myocarditis. I so found.

The Action In Contract And Negligence

E **[24]** Dr Muruga Raj, the 2nd defendant is a general practitioner and a director of Kumpulan Perubatan Raj Sdn Bhd, the 3rd defendant, Poliklinik Taj 24 Jam ('the clinic') that PW2 had brought the deceased to is owned and operated by the 3rd defendant. The plaintiffs who are the parents of the deceased
F child brought this action for damages against the defendants contending that the death of the child was caused by the negligence of the defendants and/or breach of contractual duty. The particulars of the breach of contract of the 1st defendant are set out in para. 16 and that of the 2nd and 3rd defendants in
G para. 17 of the SOC. Whereas, the particulars of the negligence of the 1st defendant are set out in para. 19 and that of the 2nd and 3rd defendants in para. 20 of the statement of claim.

Claim In Negligence

H **[25]** According to *Charlesworth & Percy on Negligence* (10th edn, 2001) the essential components of the modern tort of negligence as recognised, are three: "duty", "breach" and "resulting damage", ie,:

I 1. the existence of a duty to take care, which is owed by the defendant to the complainant

2. the failure to attain that standard of care, prescribed by the law, thereby committing a breach of such duty; and

3. damage, which is both causally connected with such breach and recognised by the law, has been suffered by the complainant.
(see para 1.23)

If the claimant satisfies the court on the evidence that these three ingredients are made out, the defendant should be held liable in negligence. (see para. 1.24).

[26] It is well settled that the burden of proof in an action for damages in negligence lies primarily with the plaintiff (see *Pickford v. Imperial Chemical Industries plc* [1998] 3 All ER 46, HL; *Sundram a/l Ramasay v. Arujunan a/l Arumugam & Anor* [1994] 4 CLJ 300; *Payremalu Veerappan v. Dr Amarjeet Kaur & Ors* [2001] 4 CLJ 380). Should the claimant fail to come up to proof on any of the ingredients, the action in negligence fails. The position is explained thus in *Halsbury's Laws of Malaysia*, vol. 5, Tort/Trusts, 2000:

> The plaintiff must show that he was injured by a negligent act or omission for which the defendant is in law responsible. This involves the proof of some duty owed by the defendant to the plaintiff, some breach of that duty, an injury to the plaintiff and proof that there is a causal connection between the breach and the injury complained of. It is insufficient for the plaintiff to prove a breach of duty without proving injury, or to prove injury without proving a breach of duty, or injury, which may or may not be caused by a breach of duty. (see para [80.187])

[27] *Charlesworth & Percy on Negligence*, *supra*, state at para. 5-01 that the plaintiff is to establish each element of the tort by adducing evidence of facts on which the claim is based. The evidence called must consist of facts, either proved or admitted and may include expert evidence if appropriate and necessary. After it is concluded, two questions arise and they are (1) whether on that evidence, negligence may be reasonably inferred and (2) whether, assuming it may reasonably be inferred, negligence is in fact inferred.

Duty Of Care

[28] The Federal Court in *Foo Fio Na v. Dr Soo Fook Mun & Anor* [2007] 1 CLJ 229 reiterated that at common law the duty of care owed by a doctor arises out of his relationship with his

patient. Without the doctor and patient relationship, there is no duty to diagnose, advice and treat his patient. The court accepted Lord Hewart CJ's description of that duty of care in *R v. Bateman* [1925] 94 LJKB 791 at 794:

> If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relation is necessary, nor is it necessary that the service be rendered for reward.

[29] The defendants argued that the plaintiffs had not proved that they owed them a duty of care. In the case of the 1st defendant, he provided the emergency medical treatment to the deceased child on the insistence of the 2nd plaintiff and as such had acted in the nature of a good Samaritan. As for the 2nd and 3rd defendants, they did not employ the 1st defendant as a doctor. Furthermore, they did not hold out the 1st defendant to the public as a registered doctor and neither were they aware that he had rendered the emergency medical treatment until after the event.

[30] The plaintiffs on the other hand argued that the 1st defendant was an unqualified doctor not entitled to practise medicine and as such, should have turned away the 2nd plaintiff at the door instead of dispensing treatment on the child. Furthermore, there was a total absence of any form of a special relationship between the plaintiffs and the defendants that would oblige the 1st defendant to be a do-gooder and play the good Samaritan. The case for an alleged emergency, they said, was made up by the defendants to justify the treatment dispensed by the 1st defendant notwithstanding his unqualified status. The plaintiffs referred to *Chai Yee Chong v. Lew Thai* [2004] 2 CLJ 321 where the Court of Appeal ruled that the law does not impose a general duty of care to be a do-gooder or a good Samaritan unless there is a special relationship between the parties.

[31] I thought it curious that the plaintiffs should contend that there was a total absence of any form of relationship between the plaintiffs and the defendants for that would mean, on their own argument, that the defendants had no duty of care towards the plaintiffs. What is more, in insisting that the 1st defendant should have turned away the 2nd plaintiff at the door, the plaintiffs in effect were conceding that the 1st defendant had no duty of care towards the plaintiffs. Be that as it may, I adopted the approach of Low Hop Bing J, as he then was, in *Chien Tham Kong v. Excellent Strategy Sdn Bhd & Ors* [2008] 1 LNS 411 that the existence or otherwise of that duty of care is a mixed question of law and fact very much dependent on the evidence adduced at the trial.

[32] The 2nd plaintiff came to the clinic and sought medical treatment for her son from the 1st defendant. The 1st defendant being merely an attachment student, unregistered and under strict instructions not to treat any one, was under no general duty to render assistance to the 2nd plaintiff. He could have with impunity ignored the 2nd plaintiff's cry for help or turned her away at the door for precisely the reason stated in *Chai Yee Chong v Lew Thai*, *supra*, that the law does not impose a general duty of care to be a good Samaritan or do-gooder unless a special relationship exist between the parties. Although that was, the 1st defendant relented and rendered treatment according as he said to the best of his knowledge. In my judgment, once the 1st defendant relented and undertook the treatment of the child, he had taken control of the situation and accepted responsibility. He therefore, in my opinion, must be regarded as entering voluntarily into a relationship of doctor and patient and hence, as assuming a duty to act. As that relationship had arisen, the 1st defendant owed a duty to the child and his parents to use due diligence, care, knowledge, skill and caution in administering treatment.

[33] I could not, in my research, find any reported Malaysian decision on point, but there is the Canadian case of *Mathews v. McLaren, Jones and The Ogopogo Horsley and Others* [1969] 1 Lloyd's Rep. 374 which I found to be instructive and from which parallels can be drawn in resolving this difficult if not novel issue. *Charlesworth & Percy on Negligence*, *supra*, discuss the case at length at paras. 2-68, 2-69. The relevant facts are these. M and H were invited guests on board D's pleasure cruiser Ogopogo on a trip across Lake Ontario but M fell overboard. After D's abortive

attempts to save M had been made, H dived into the water in a rescue attempt. M was lost and H died from shock sustained upon contact with the icy water. On the claim by M's dependants in negligence, the Ontario Supreme Court held that D's failure to ensure that his visitors wore life belts was not actionable negligence since the relationship required a legal duty in D to aid and to rescue. However, once he had taken positive steps in a rescue bid, he was, by law, regarded as having assumed a duty to act and, thus, would be liable thereafter for negligence if it caused M's death, that is by preventing his life being saved. Lacourciere J said at p. 379:

> In any event, if the defendant, as he did here, affirmatively undertakes the rescue operation, he is by law regarded as assuming a duty to act, and will thereafter be liable for his negligence: *Prosser on Torts*, (1941), at pp. 194 to 195, puts it this way:
>
> > But further, if the defendant attempts to aid him, and takes control of the situation, he is regarded as entering voluntarily into a relation of responsibility, and hence assuming a duty. Thereafter he will be liable for any failure to use reasonable care in dealing with him, until the emergency has ended, and particularly if he abandons him in a position of danger.

[34] On the claim by H's dependants, Lacourciere J held that D's negligence, in effecting M's rescue, had induced H to come to the rescue and such negligence was the cause of H's death. M's dependants abandoned an appeal against the dismissal of their action whereas D appealed against the finding of negligence against him in respect of H's death.

[35] In allowing D's appeal, the Canada Supreme Court of Ontario Court of Appeal (see [1970] 1 Lloyd's Rep. 257] held, *inter alia*, that:

(a) it was immaterial whether D was under a duty to rescue M, since he voluntarily had undertaken a rescue operation;

(b) D was not primarily negligent and hence responsible for M's flight in the first instance; and

(c) D would be under no liability to M, if he had abandoned rescue operations once undertaken, if discontinuance of such had not left M in a worse condition than when D had taken charge and his efforts had not left M in a worse condition.

[36] On further appeal by H's dependants, the Canadian Supreme Court (see [1971] 2 Lloyd's Rep. 410) held that if a host or owner and operator of a vessel embarked upon the active task of rescuing a guest, who has accidentally fallen overboard, albeit the former was not normally under any duty to play the good Samaritan, he could become liable in negligence, were the method of rescue or its abandonment to leave the person, who was in danger, worse off then otherwise would have been the case.

[37] In our present case, the 1st defendant had similarly chosen to act and embarked upon the task of treating the child thereby coming to its aid. He was not obliged to do so and could have with impunity, as suggested by the plaintiffs, turned away the mother at the door. In coming to the aid of the child, he had in my opinion entered voluntarily into a relation of responsibility and hence assuming a duty. Thereafter he will be liable for any failure to use reasonable care in dealing with the child until the emergency has ended. Hence, on the facts established I found that the 1st defendant owed a duty to the plaintiffs to use due diligence, care, knowledge, skill and caution in administering treatment to the child.

[38] With regard the 2nd and the 3rd defendants, they are the owners of the clinic and run it. The question is whether the clinic was under a duty to treat the deceased child. The onus was on the plaintiffs to establish that the 2nd and 3rd defendants owed a duty to treat the child in the circumstances in which he presented at the clinic. The plaintiffs did not lead evidence on this. In any event, it is well established, that hospitals are liable vicariously for the negligence of members of staff, including nurses and doctors. *Charlesworth & Percy on Negligence* (10th edn, 2001), at para 8-131 write that for "most purposes the duty of care owed by a hospital authority is co-extensive with the duty owed by the medical staff for whom it is vicariously liable." In my view, the clinic in the present case is analogous with a hospital. The 1st defendant, being merely an attachment student under strict instructions not to treat any patient, was never an employee or a staff of the clinic.

Moreover, there was no evidence that the 2nd and 3rd defendants had ever held him out to be a doctor or staff employed by the clinic. That being so, there was no question of the clinic being vicariously liable for the negligence, if any, of the 1st defendant in meting out treatment. Hence, the 2nd and the 3rd defendants owed the plaintiffs no duty of care in the first place.

Was There A Breach Of Duty Of Care?

[39] Having found a legal duty to take care upon the voluntary assumption of duty on the part of the 1st defendant, the next question is the standard of care required of him in the performance of such duty. The defendants argued that the standard of care is as settled by the Federal Court in *Foo Fio Na v. Dr Soo Fook Mun & Anor*, *supra*. At the heart of the decision in *Foo Fio Na* is the standard of care applicable in medical negligence and the method of deciding whether the duty of care has been breached. The Court of Appeal in *Hasan Datolah v. Kerajaan Malaysia* [2010] 5 CLJ 764 stated that *Foo Fio Na* represents an outright rejection of the *Bolam* test (as in *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118) in favour of the test in *Rogers v. Whitaker* [1992] 175 CLR 479. Moreover, contrary to the suggestion of the plaintiffs that it is confined to cases involving negligence in giving medical advice to patients, the Court of Appeal stated that the *Rogers v. Whitaker* test applied to all aspects of medical negligence (see para. [10-11]).

[40] The test in *Rogers v. Whitaker* is that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that skill. That standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade. Elaborating on this test, Low Hop Bing J (as he then was) said as follows in *Chien Tham Kong v. Excellent Strategy Sdn Bhd & Ors*, *supra*:

> This test dictates that the court and not the medical profession must decide on the liability of doctors who are defendants in medical negligence actions. In so deciding, our courts are at liberty to reject medical expert evidence which does not really stand up to logical analysis, but instead must scrutinize and evaluate the relevant evidence in order to adjudicate on the

> appropriate standard of care. Due regard must be had to the relevancy of the opinion of experts in line with s. 45(1) of the Evidence Act 1950, which provides that when the court has to form an opinion upon a point of eg science, the opinions upon that point of persons specially skilled in that science are relevant facts. In the context of the instant case, the opinions of the doctors specially skilled in medical science, with particular speciality in spinal cords, neurology and stroke are relevant. (see para. 60)

In *Hasan bin Datolah's* case, *supra*, the Court of Appeal said:

> The *Rogers v. Whitaker* test was explained with clarity by Gleeson CJ in another Australian High Court case of *Rosenberg v. Percival* (2001) 178 ALR 577, in the following words, at p 579:
>
> > ... *Rogers v. Whitaker*, makes clear, the relevance of professional practice and opinion was not denied; what was denied was its conclusiveness. In many cases, professional practice and opinion will be the primary, and in some cases it may be the only, basis upon which a court may reasonably act. But, in an action brought by a patient, the responsibility of deciding the doctor's duty of care rests with the court, not with his or her own professional colleagues. [See para. 10]

[41] The plaintiffs contended that the test in *Rogers v. Whitaker* is not applicable to the 1st defendant because he was never a person who possessed a special skill or competence, more so as he was not allowed by law to practise medicine at the material time. They argued that applying the *Rogers v. Whitaker* test in this manner would result in charlatans, practitioners of alternative medicine, medical students, disbarred doctors and imposters to seek the protection of the standard of care afforded to the legal branches of the medical profession. The 1st defendant, they say, in giving medical treatment to the deceased child whilst unqualified/unregistered was a charlatan, a quack doctor in the same manner that the defendant in the case of *Poonam Verma v. Ashwin Patel & Ors* AIR 1996 SC 2111 was likened to. In that case, a doctor registered as a medical practitioner and entitled to practice in Homotheopathy only, treated a patient in the Allopathic System of Medicine despite having not studied that system. The patient died. The doctor was held to be negligent on the ground that he was entitled to practise in homoeopathy only and under a statutory duty not to enter the field of any other

system of medicine. Since he trespassed into a prohibited field and prescribed the allopathic medicine causing the patient's death, his conduct amounted to negligence *per se* actionable in civil law. The court branded him a quack Allopathic doctor to boot.

[42] The defendants countered by saying that whilst technically unqualified or unregistered at the relevant time, the 1st defendant was somewhat more than a medical student as he had passed his MBBS in November/December 2000. Moreover, he was working with a Malaysian government hospital in 2001 during his internship period until obtaining provisional registration. Dr Wan Mazlan (PW1), the Secretary of the Malaysian Medical Council, agreed that it was an accepted practice at that time because of the shortage of doctors. The defendants therefore submitted that the 1st defendant was a person possessed of a special skill or competence.

[43] I agreed with the defendants on this. The reason is clear. The fact of registration would not have made a more skilled or competent a person out of the 1st defendant in the field of medicine. Conversely, the lack of it would not have made him any less skilled or competent in his training. This is because at the relevant time, the 1st defendant had completed medical school and had passed his medical degree examinations (MBBS) back in November/December of 2000. Moreover, in 2001, he was undergoing internship at the government hospital thus getting some work experience. Registration would be a mere formality. In amplification of this, one has only to consider the fact that the 1st defendant received provisional registration under the Medical Act 1971 on 27 February 2001 ie, only 11 weeks after the incident. In my judgment, to all intents and purposes, the 1st defendant at the relevant time was qualified as a medical doctor and for that reason was possessed of a special skill or competence.

[44] *Charlesworth & Percy on Negligence* (10th edn., 2001) writing on the standard of care and degree of skill required of someone executing a task requiring special skill state as follows (at para. 6-45; 6-46):

> The Bolam test is of general application and is not confined to a defendant exercising or professing the particular skill of medicine. [*Gold v. Haringey Health Authority* [1988] QB 481 at 489, per Lloyd J] So, the law requires that a person, in doing such act,

> shall exercise the skill of an ordinary competent human being of the same calling. The standard of care is that he should do "all that any skilful person could reasonably be expected to do in such a case". [*Jones v. Bird* (1822) 5 B. & Ald. 837 at 845, per Bayley J] *A person driving a motor car on the highway, for example, was bound to exercise the skill of a reasonably careful driver, even before the introduction of driving tests, and, if he failed to do so, was not excused by the fact that he was using such care and skill as he possessed. The standard of care is not affected or reduced merely because the driver happens to be a learner driver, since he must comply with the same objective and impersonal standard as must every other driver.* [*Nettleship v Weston* [1971] 2 QB 691] The principle stated above does not depend on the fact that a person holds himself out as having any special skill; it is based on the actual performance of an act which can only safely be done by a person with skill necessary to do it. For example, a surgical operation must be performed in the way that a skilled surgeon, who is accustomed to perform that operation, would perform it. *With the likely exception of a sudden and serious emergency, it would be no defence, where damage ensued, as a result of unskillful performance, that the unskilfulness arose from the operator's lack of surgical qualification or from any other cause.* (emphasis added)

[45] In my view, in the same way that the *Bolam* test is of general application in England, so is the test in *Rogers v. Whitaker* in Malaysia, which as a matter of *stare decisis*, is applicable to all persons with some special skill or competence. The 1st defendant in the present case having obtained his medical degree at the material time, was possessed of a special skill and competence bringing him well within the purview of the test in *Rogers v. Whitaker*. Just as in the case of the learner driver in *Nettleship v. Weston*, *supra*, the standard of care required of the 1st defendant in treating the deceased child is not affected or reduced merely because he was not fully registered as a medical practitioner. Conversely, the 1st defendant, if the death of the deceased child was caused by his unskillful performance, could not plead that his unskilfulness arose from his lack of qualification. For this reason, I totally disagreed with learned counsel for the plaintiffs that the *Rogers v. Whitaker* test does not apply to the 1st defendant.

[46] I find further support for this view in the same judgment of Lord Hewart CJ in *R v. Bateman*, *supra*, where His Lordship continued and stated as follows at p. 794:

> The law requires a fair and reasonable standard of care and competence. This standard must be reached in all the matters above mentioned. If the patient's death has been caused by the defendant's indolence or carelessness, it will not avail to show that he had sufficient knowledge; nor will it avail to prove that he was diligent in attendance, if the patient has been killed by his gross ignorance and unskilfulness ... *As regards cases where incompetence is alleged, it is only necessary to say that the unqualified practitioner cannot claim to be measured by any lower standard than that which is applied to a qualified man. ... In the case of a quack, where the treatment has been proved to be incompetent and to have caused the patient's death, juries are not likely to hesitate in finding liability on the ground that the defendant undertook, and continued to treat, a case involving the gravest risk to his patient, when he knew he was not competent to deal with it or would have known if he had paid any proper regard to the life and safety of his patient.* (emphasis added).

[47] Thus, the unqualified practitioner or even a quack cannot claim to be measured by any lower standard of care than that which applies to the qualified man. The same is true of the 1st defendant in the present case. Though he may not be fully registered under the Medical Act or even if he were a quack, as the plaintiffs insisted he was, he still could not be measured by any lower standard than the fully registered or qualified practitioner. That is to say, the test in *Rogers v. Whitaker* still applies to him notwithstanding his lack of qualification.

[48] As for *Poonam*'s case, I would say that it is unnecessary to import Indian principles into the area of medical negligence in Malaysia, which is already well defined by the Federal Court and the Court of Appeal. This is the more so in light that *Poonam*'s case was a finding of negligence arising from a breach of statutory duty, which may be very different from the position in Malaysia.

[49] The next question is whether there was a failure to attain the standard of care as enunciated in *Rogers v. Whitaker*. The test here is: what the reasonable medical doctor ought to have done in the circumstances of the present case attributing to such person the care and skill of an ordinary competent medical doctor. The *Rogers v. Whitaker* test dictates that the court is to determine what the reasonable doctor would have done and not the medical profession. What the profession does in the given situation will be an important indicator of what ought to have been done, but it

should not necessarily be determinative. In the final analysis, the court sets the standard of care in negligence drawing upon the evidence presented.

[50] The plaintiffs by para. 19 of the statement of claim have set out the particulars of the alleged breach of professional duty of care of the 1st defendant in these terms:

(a) failure to carry out a thorough examination of the deceased child

(b) failure to observe normal procedure in treating the child

(c) failure to obtain the child's history of allergy or adverse reaction to drugs

(d) giving an injection of 1.5 cc I/M of Voltaren to a young child

(e) failure to consider that the side effects of administering Voltaren outweighs the benefits it brings

(f) failure to foresee the probability of the deceased child suffering from extreme adverse reaction to Voltaren

(g) failure to inform and advise the plaintiff of the side effects of Voltaren

(h) failure to acquaint himself with the probable side effects of Voltaren

(i) failure to take reasonable measures to overcome the side effects of Voltaren

(j) taking on responsibilities beyond his skill and qualifications

(k) failure to refer the child to a medical doctor or specialist medical doctor within good time and

(l) failure to diagnose typhoid when treating the deceased child on 1 December 2001 and at any other time thereafter.

[51] The alleged breach of the professional duty of care of the 2nd and 3rd defendants are pleaded in para. 20 of the statement of claim as follows:

(a) failure to have a proper system in place for emergency medical treatment of the nature suffered by the deceased;

A (b) failure to ensure that the deceased was referred to a medical doctor or specialist within good time;

(c) failure to ensure that a medical doctor was on hand at the clinic to take all appropriate action on the deceased;

B (d) failure to render quick response to the emergency medical condition of the deceased;

(e) failure to take reasonable steps to prevent the death of the deceased child; and

C (f) failure to ensure that only a doctor registered with the Malaysian Medical Council would render treatment to the deceased child.

D **[52]** The pleadings notwithstanding, counsel for the plaintiffs at the conclusion of trial submitted that the breaches of duty of care of the 1st defendant consisted in:

(a) treating the child notwithstanding his inability to communicate with the mother, thereby depriving him of the ability to ask E about the child's history, medical condition, allergies, history etc;

(b) failing to take the child's blood pressure because the clinic lacked the paediatric cuff;

F (c) failing to turn away the deceased child's mother at the door, referring her to a hospital in light of the very serious nature of the child;

(d) failing to call an ambulance for the child, notwithstanding G admitting he knew the child's condition to be very serious, even life threatening;

(e) choosing to treat the child notwithstanding his admitted lack of knowledge in paediatric care and experience and total H absence of equipment;

(f) failing to inquire into the family history, the condition of the child's siblings and therefore totally failed to consider the possibility that the child was suffering from typhoid; and

I (g) rendering treatment that was inappropriate for typhoid.

[53] In respect of the 2nd and 3rd defendants the plaintiffs submitted that the breach of duty of care consisted of the following:

(a) they allowed for and created and permitted an environment whereby an unqualified person will be left alone to deal with potential patients;

(b) they allowed for a clinic which did not have the provision for an ambulance service notwithstanding their stated avowed business in the company's business registration as providing, *inter alia*, ambulance services;

(c) allowing for a clinic which did not have the necessary medical equipment necessary to treat paediatric cases; and

(d) failure to ensure that adequate and qualified medical care is available at all times in the clinic the more so when the clinic is stated to be a 24 hour clinic.

[54] It has been said before that because the legal burden of proof rests on the plaintiffs, it is not for the defendants to disprove allegations as contained under the particulars of negligence in the statement of claim (see *Payremalu Veerappan v. Dr Amarjeet Kaur & Ors* [2001] 4 CLJ 380). Nonetheless, the defendants had called an expert witness that was DW1.

[55] The plaintiffs attacked DW1's credibility and submitted that his evidence was suspect and inconclusive for reasons as follows:

(a) he purportedly only found out during cross-examination that the 1st defendant was unqualified to practice medicine. If that is so, the court should query what exactly was in DW1's brief given that he appeared clueless as to the lack of qualification on the part of the 1st defendant in giving the treatment;

(b) all that DW1 had to go on was the Pathologist's report and the history of the siblings, yet his opinion and testimony appeared so complete;

(c) his inability to state who manufactures Voltaren despite his grandstanding that "I teach doctors with administration of drugs and I am familiar with it and use it" only impact negatively on his evidence; and

(d) DW1 was combative during cross-examination and that was unnecessary. His manner during cross-examination underlined his intention to clear the plaintiffs of any misconduct in any case. He actively defended the conduct of the defendants; actively proffered excuses for the clinical settings available to the defendants to justify the manner and standard of treatment; and actively supported the emergency argument of the defendants.

[56] In my opinion, DW1's ignorance of the 1st defendant's lack of registration would only be of significance if his evidence would have been drastically different had he known of the fact beforehand. His evidence pertained, *inter alia*, to the use of Diclofenac Sodium; whether its administration was permissible in the circumstances or whether it caused death; the diagnosis and treatment of typhoid; the cause of death; the findings in the post mortem report; and above all, what ought to be done in an emergency. The lack of registration has no bearing and does not make a difference to the evidence of DW1.

[57] On the suggestion that DW1's not knowing who manufactures Voltaren injures his credibility, to my mind, such ignorance was hardly of any consequence. This is because Diclofenac Sodium, in any event, is a drug that the Ministry of Health has approved for practice in Malaysia. The latter is a fact not denied or contradicted by the plaintiffs. Besides, it is DW1's evidence that he is familiar with Diclofenac Sodium as he uses it and teaches students and doctors on its use. These too are matters not denied or challenged by the plaintiffs.

[58] As for disparaging DW1's evidence for appearing to be so complete despite the alleged dearth of reference sources, I think this is unwarranted. In the first place, it is not true that DW1 had only the pathologist's report and the history of the siblings to go by. DW1 testified that he referred to other reports namely, the expert medical report of Professor Kasinathan Nadesan (a witness appearing on the plaintiff's list of witnesses that in the end was never called to testify), a medical report by the 3rd defendant, two medical reports under the hand of Dr Alex Tang and two police reports of the 1st plaintiff. Secondly, it does not make sense that when an expert is complete and compelling in his expert opinion, it somehow makes suspect his evidence or lessens its cogency.

This is especially so when the plaintiffs had singularly failed to contradict DW1's evidence or offer any alternative explanation. Rather, in my judgment, DW1's clarity on the issues upon which he was called to give his opinion was well founded and based upon his expertise and experience on the subject-matter.

[59] As for saying that DW1 was combative and appeared to defend the actions of the defendants, I think this is a misapprehension. It might have been that DW1 was forceful in expressing his opinion but in my judgment that was merely indicative of a mind confident and sure of the subject-matter in question. Moreover, it is unfair to suggest during submission stage that DW1 appeared very eager to defend the actions of the defendants when such a proposition was never put to him during cross-examination. In fact, the cross-examination of DW1 only served to enhance the cogency of his expert evidence and this very well might have given reason to the plaintiffs to rue the fact that his evidence stands unrebutted, thus the attempt at discrediting his evidence.

[60] For the reasons aforesaid, I quite agree with the defendants that the broadside on the credibility and expertise of DW1 was largely unwarranted. There was no denying that DW1 is highly qualified and an eminent personality in the medical profession. His background includes the practice and teaching of medicine at even postgraduate level. He is qualified in anaesthesiology and critical care (peri-operative care, resuscitation, intensive care, pain relief) and was responsible in setting up the first ICU in the country on 18 January 1968 at the University Hospital in Kuala Lumpur. He has treated and managed cases of acute septicaemic shock caused by infections including cases caused by typhoid. He had given expert evidence on 25 occasions in the courts in Malaysia, Singapore, Hong Kong and Australia. I was quite satisfied that the opinions he expressed in court are well within his area of expertise. The plaintiffs did not call any expert to rebut his evidence; it therefore stood unchallenged. The authorities are clear that professional practice and opinion although not conclusive is nevertheless relevant. Gleeson CJ said as much in *Rosenberg v. Percival*, *supra*, and so did Low Hop Bing J (as he then was), in *Chien Tham Kong v. Excellent Strategy Sdn Bhd & Ors*, *supra*. In *Rosenberg v. Percival*, Gleeson CJ stated that in many cases, professional practice and opinion would be the primary, and in

some cases, may be the only basis upon which a court may reasonably act. This statement from Gleeson CJ, as previously indicated, met with approval by our Court of Appeal in *Hasan bin Datola* case, *supra*. In the context of the present case, the opinion of DW1 who had particular expertise in critical care management was not only relevant but in the absence of any other expert evidence to the contrary, it was the only basis upon which the court could reasonably act.

[61] In giving his opinion on what a medical practitioner would have done in the circumstances of the present case, DW1 stated that considering that the scenario was one of a parent bringing a seriously ill child to the clinic and running in to get help, it is an emergency. The doctor comes out to assess the situation. The patient is a young child with a high temperature of 40°C and not conscious. The doctor is immediately faced with an emergency outside a hospital that is life threatening. As the high temperature is immediate and staring the doctor in the face, DW1 was of the opinion that the focus of the doctor whether qualified or not, would be to bring down the temperature and direct the patient to the nearest hospital to an intensive care setting.

[62] With regard the methods of controlling the fever in that scenario, DW1 was of the opinion that sponging would be one way; another way would be using an anti-fever drug; and thirdly, controlling the infection if the doctor knows what is causing the fever. In response to the plaintiffs' suggestions that the 1st defendant should not have administered Voltaren to the deceased being only a child and that in any case it should have been by rectal suppository instead of by injection, DW1 stated that the use of Voltaren was appropriate to bring down the temperature. Voltaren being non-steroidal and anti-inflammatory is used for mild moderate pain control. Thus, doctors confronted with situations of uncontrolled high fever commonly use it in private practice. Moreover, when the Ministry of Health approved Voltaren for practice in Malaysia, there was no mention it should not be used on children. In any event, the dosage given by the 1st defendant to the deceased child in this case was appropriate.

[63] In relation to the route taken in administering Voltaren, DW1 said that the aim is to get the drugs into the blood stream. If it is by intramuscular injection, it takes a bit longer to be deposited in the muscle to be absorbed into the blood stream. On

the other hand, if suppository is used, absorption would be faster because the mucosal lining in the rectum in the anal region has many vessels. He emphasised that this does not mean there is danger in one method compared to the other. Doctors that treat children do not generally use needles to administer drugs because the needle causes pain and pain causes a child to develop a phobia of doctors and hospitals. Suppository on the other hand is not painful. It is for that reason that the needle is not used on children and not because there is danger associated with intramuscular injection.

[64] With regard the failure to diagnose typhoid, DW1 said that if the presentation is the slow build up where the doctor has an idea, he could take the blood samples to try to detect the typhoid organism. Alternatively, he can take the blood and send it for immunological changes regarding the level of antibodies being produced because of this particular infection. Either way it takes a bit of time for the results to come out. However, in the setting of a clinic in an emergency where the patient presented with temperature of 40°C and for a period of ten minutes or less, the doctor would not have been able to diagnose septicaemic shock from typhoid because there is no history. The doctor could only deal with the fever to try bring the temperature down and then send to the nearest hospital. The specific treatment for septicaemic shock would be to give antibiotics and use of drugs to enhance the heart pump that is failing. However, this specific management of septicaemic shock is only available in the ICU and not anywhere else such as in the setting of a clinic.

[65] Therefore, with reference to the evidence of DW1, it stood unchallenged and unrebutted by expert medical evidence to the contrary. Hence, it was the only basis upon which I could reasonably act. Furthermore, I found it to be pragmatic and accorded with common sense. In the circumstances, I accepted his evidence and acted upon it. For that reason, I found that the 1st defendant was confronted with an immediate and pressing emergency when the 2nd plaintiff brought the deceased child to the clinic at 5pm that day. I found that in that emergency case scenario, the treatment that the 1st defendant provided to the deceased child was appropriate and in accordance with the standard of care required of a medical doctor in the circumstances of the case. This is because, as DW1 said, all that any doctor

would do in the same circumstances would be to attempt to reduce the child's temperature and refer him to a hospital. The 1st defendant did attempt to reduce the child's temperature by cold water sponging and administration of Diclofenac Sodium. The administration of Diclofenac Sodium by intramuscular injection rather than suppository was safe and appropriate for treating high fever of 40°C and in accordance with accepted medical practice. This remains true whether the 1st defendant was registered or not. In my judgment, the 1st defendant could not be said to have failed to attain the standard of care required of him in the treatment that he provided.

[66] As for the added obligation to see that the child was sent to a hospital after attempting to reduce the high temperature, the 1st defendant did instruct the 2nd plaintiff to straightaway bring the child to a hospital. The plaintiffs said that the 1st defendant should instead have called an ambulance knowing that the child's condition was serious and life threatening. I should put on record that the plaintiffs in their SOC had not pleaded the matter of the failure to call an ambulance as one of the particulars of the negligence of the defendants. Nonetheless, as it had cropped up at the trial and parties have submitted on it, it needed to be considered. I had in mind that it is a well-known fact that ambulances can take some time to arrive. Given that the 2nd plaintiff had arrived at the clinic by car, it meant that she had the necessary means of transport at her disposal and as instructed by the 1st defendant, could reasonably be expected to drive straightaway to the hospital from the clinic with the child. Under the circumstances, the explanation of the 1st defendant that he did not call for the ambulance because he believed it would be faster for the 2nd plaintiff to take the child herself, in my judgment, was reasonable. For that reason, I did not find any breach of duty of care in this.

[67] The plaintiffs next said that in light that the child's condition was critical and the 1st defendant could not get the child's history because of the language barrier, the 1st defendant should have turned away the child's mother at the door. To be sure, the 1st defendant did attempt to turn away the mother at the door when he asked her to go directly to the hospital after seeing the child unconscious in the back seat of the car. I found that he had relented to treat the child after the 2nd plaintiff's entreaties and

out of a desire to help in light of the serious condition of the child. As DW1 puts it, the high temperature stares the 1st defendant in the face. In my judgment, given that the 1st defendant at that time was qualified as a medical doctor and thus possessed of some skill and knowledge in administering medical treatment, he could not have done better than to render emergency aid to this child. The emergency aid was to attempt to bring down the high temperature, which according to the expert evidence was the appropriate thing to do in the circumstances. I was of the opinion that given the circumstances, rendering emergency medical treatment rather than turning away the mother at the door was the reasonable, decent and right thing for anyone in the shoes of the 1st defendant to have done. Hence, I found I could not agree with the plaintiffs that the 1st defendant was in breach of his duty of care in not turning away the child's mother at the door.

[68] On the 1st defendant's failure to diagnose typhoid, the clear and uncontradicted evidence of DW1 is that neither the 1st defendant, nor any doctor could have diagnosed typhoid in the circumstances without full laboratory tests being taken. Without such tests, the symptoms exhibited by the child could be attributed to any number of causes. Even Dr Shahidan was unable to diagnose typhoid from a full autopsy, but agreed it would have made a difference to his findings if he had been told that the other siblings had been diagnosed with it shortly after the child's death. As for rendering treatment that was purportedly inappropriate for typhoid, as already mentioned, the 1st defendant could not have known that the child was suffering from typhoid. In any case, the cause of death was acute septicaemic shock (sepsis) from an infection for which treatment could only have been given in a hospital ICU.

[69] For the reasons given above, I found that the plaintiffs had failed to prove on balance of probabilities that the 1st defendant had failed to attain the standard of care required of him. Since the plaintiffs had failed to come to proof on this ingredient, the action in negligence against the 1st defendant necessarily failed.

[70] With regard the breach of duty of care on the part of the 2nd and 3rd defendants, since I found they owed no duty of care towards the plaintiffs, there was no question of any breach. Nevertheless, for the sake of argument in the event I am wrong,

I will say this. The burden of proof being primarily with the plaintiffs to prove negligence, it was incumbent on them to adduce evidence to establish the standard of care required of the 2nd and 3rd defendants. It is only then that it would be possible to assess whether there had been a breach of that duty of care. As Kang Hwee Gee J (as he then was) observed in *Wu Siew Ying v. Gunung Tunggal Quarry & Construction Sdn Bhd & Ors* [1999] 4 CLJ 339 at p 356:

> A breach of such a duty of care cannot be established by merely enumerating what the operator had failed to do and what he ought to have done. In the words of Abdul Malek Ahmad JCA in *Dr. Chin Yoon Hiap v. Ng Eu Khoon & Ors and other appeals* [1998] 1 MLJ 57 at pp 76-77, when speaking for the Court of Appeal on the standard of care expected of a medical practitioner in a claim in a medical negligence:
>
> > Lord Fraser of Tullybelton said in *Whitehouse v. Jordan & Anor* [1981] 1 WLR 246 at p 263 that merely to describe something as an error of judgment tell us nothing about whether it is negligent or not. The true position is that an error of judgment may, or may not, be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand it is an error that such a man, acting with ordinary care, might have made, then it is not negligent.

[71] The essence of the complaint of the plaintiffs against the 2nd and 3rd defendants is that they failed to have in place a set up or a proper system for emergency medical treatment of the illness as suffered by the deceased. The plaintiffs submitted that the defendants allowed for, created and permitted an environment whereby an unqualified person would be left alone to deal with potential patients. The issue of public interest, they said, was at stake here to ensure that clinics, which open their doors to the public, are held to account for their system of work.

[72] In my opinion this was merely enumerating what the 2nd and 3rd defendants had failed to do and ought to have done. No evidence was forthcoming on the standard of care that was required of a reasonably competent owner and operator of a

private clinic such as the 3rd defendant so as to enable the court to reach a finding whether the 2nd and the 3rd defendants had breached their duty of care. In light that the 3rd defendant is a private clinic, were they required to have in place a set up or a proper system for emergency medical treatment of the illness as suffered by the deceased? The plaintiffs did not lead evidence on this. In fact the uncontradicted evidence of DW1 is that only the ICU in hospitals are equipped for critical care or emergency medical treatment such as that suffered by the deceased. Did the 2nd and 3rd defendants hold out the clinic as a place for emergency medical treatment of the nature suffered by the deceased? There was no evidence of that. Furthermore, there was no evidence that the 2nd and 3rd defendants had held out the clinic as being able to provide continuous 24 hour emergency treatment nor that they have an obligation in law to have a doctor available 24 hours to immediately treat emergency cases. With regard the fact that the 2nd defendant and the nurse had gone out briefly for tea, it was never intended that the 1st defendant treat any patients in their absence. Therefore, the 2nd and the 3rd defendants could not have foreseen this emergency in which the 1st defendant felt compelled to administer emergency treatment. In the normal situation, the patient would have waited for the doctor and nurse to return a short time later. For that reason, there was no breach of duty in the fact that the 2nd defendant and the nurse took a short break for tea.

[73] For the reasons given above, I still could not, for the sake of argument, come to the conclusion that the 2nd and 3rd defendants had breached any duty of care. That being the case, the negligence of the 2nd and 3rd defendants was not proved on balance of probabilities.

Causation

[74] In view of the findings above, the issue of causation would be merely academic. Nevertheless, I thought to consider it for the sake of argument in the event I am wrong that the defendants did not breach any duty of care.

[75] It is well settled that liability does not follow a finding of negligence, even where there exists a legally recognised duty or breach of such duty, unless the defendant's conduct is the

effective cause of the loss. Lord Justice Denning spoke of this principle in *Cork v. Kirby Maclean Ltd* [1952] 2 All ER 402 at 407 in this way:

> Subject to the question of remoteness, causation is, I think, a question of fact. If you can say that the damage would not have happened but for a particular fault, then that fault is in fact a cause of the damage; but if you can say that the damage would have happened just the same, fault or no fault, then the fault is not a cause of the damage ...

[76] *Clerk & Lindsell on Torts* (18th edn., 2000) elaborate on this so-called "but for" test at para. 2-06:

> The first step in establishing causation is to eliminate irrelevant causes, and this is the purpose of the "but for" test. The courts are concerned, not to identify all of the possible causes of a particular incident, but with the effective cause of the resulting damage in order to assign responsibility for that damage. The "but for" test asks: would the damage of which the claimant complains have occurred "but for" the negligence (or other wrongdoing) of the defendant? Or to put it more accurately, can the claimant adduce evidence to show that it is more likely than not, more than 50 per cent probable, that "but for" the defendant's wrongdoing the relevant damage would not have occurred. In other words, if the damage would have occurred in any event the defendant's conduct is not a "but for" cause.

[77] The plaintiffs, however, took the position that on the facts established by the evidence, the 1st defendant was guilty of negligence *per se* in accordance with the principle of *res ipsa loquitur* ie, the facts speak for themselves. The salient facts that the plaintiffs said speak for themselves are as follows:

(a) the 1st defendant treated the deceased child notwithstanding his lack of qualification;

(b) he treated the child notwithstanding his admitted lack of knowledge in paediatric care;

(c) he administered the child with Voltaren notwithstanding his complete absence of knowledge about its administration;

(d) he administered the child with Voltaren *vide* injection because the clinic lacked the suppository;

(e) he treated the child notwithstanding his inability to communicate with the mother thereby depriving him of the ability to ask about the child's history, medical condition, allergies, history etc.

(f) he failed to take the child's blood pressure because the clinic lacked the paediatric cuff;

(g) he failed to turn away the child's mother at the door, referring her to a hospital in light of the very serious nature of the child;

(h) he failed to call an ambulance for the child, notwithstanding admitting that he knew the child's condition to be very serious, even life threatening; and

(i) he chose to treat the child notwithstanding his total absence of knowledge, paediatric experience and equipment.

[78] But, before recourse can be had to the *maxim res ipsa loquitur*, as suggested in the leading case of *Scott v. London and St Katherine Docks Co* (1865) 3 H & C 596, three conditions must be satisfied. These are summarised in *Clerk and Lindsell on Torts* (18th edn.) at paras. 7-192 as follows:

(a) the occurrence is such that it would not have happened without negligence; and

(b) the thing that inflicted the damage was under the sole management and control of the defendant, or of someone for whom he is responsible or whom he has a right to control;

(c) there is no evidence as to why or how the occurrence took place; if there is such evidence, then appeal to *res ipsa loquitur* is inappropriate for the question of the defendant's negligence must be determined on such evidence.

[79] What is of relevance to the present case is the 3rd condition, above. There can be no denying that there is evidence in the instant case as to why or how the death of the child occurred. The child was brought unconscious with a temperature of 40°C to the clinic. The 1st defendant administered treatment that included an injection of Voltaren. The child was taken away

still in the same condition he was brought in and expired upon arrival at the hospital. The cause of death is known and it is myocarditis brought about by acute septicaemic shock (sepsis) from an infection that was likely typhoid. In *Joginder Kaur & Anor v. Malayan Banking Ltd & Anor* [1970] 1 LNS 41; [1971] 1 MLJ 98 FC, Ong CJ (Malaya) said at p. 99:

> [T]he doctrine 'does not apply where the cause of the accident is known … the res speaks because, and only because, where the accident stands unexplained, the known facts and circumstances, however meager, may be such that want of reasonable care is safely attributable to the person but for whose negligence the accident could not have happened … conversely *res ipsa loquitur* cannot be relied on where the *res* is ambivalent.

In the same way, in as much as the circumstances and cause of death of the deceased child were sufficiently known, the plaintiffs could not avail themselves of the *res ipsa loquitur* doctrine to infer negligence on the part of the defendants. And because the facts are sufficiently known, as Lord Porter explained in *Barkway v. South Wales Transport Co Ltd* [1950] 1 All ER 392 at 395, "the question ceases to be one where the facts speak for themselves, and the solution is to be found by determining whether on the facts as established, negligence is to be inferred or not." That being the case, the burden remained on the plaintiffs to prove breach of duty, injury and causation on the facts established.

[80] It follows that the next question was whether on the facts established, it was proved on balance of probabilities, that the death of the deceased child would not have occurred but for the negligence of the defendants.

[81] The plaintiffs in their submission appeared to have relied on the same set of facts outlined in paras. 50, 51, 52 and 53 above to show the causative link or to infer negligence of the defendants. The plaintiffs contended that these breaches resulted in the following:

(a) available and better alternatives not taken into account and possibilities not considered;

(b) delay in getting appropriate and qualified care for the child; and

(c) failure to diagnose; failure to have proper medication; and failure to have proper equipment, staffing and a qualified person on hand.

[82] The first set of facts relied on by the plaintiffs has to do with the lack of qualification of the 1st defendant and his admitted lack of knowledge in paediatric care. The question arising was did his lack of qualification and lack of knowledge in paediatric care cause or contributed to the death of the deceased child? To my mind, lacking qualification as in not yet being fully registered under the Medical Act does not in itself establish negligence. An analogy can be drawn from the case of an unlicensed driver of a motor vehicle involved in an accident. In *Siti Rohani Mohd Shah & Ors v. Hj Zainal Hj Saifiee & Anor* [2001] 1 CLJ 498 Jeffrey Tan J (as he then was) observed at p. 508:

> It is very clear riding or driving without a valid licence *per se* is not negligent. ... But riding or driving without a valid licence *per se* would not enter into the cause of an accident. Rather, it is the manner of the riding or driving and/or conduct on or in relation to the road that enter into the cause of a motor accident or collision. In the present case, the fact that the first appellant was riding the motorcycle without a valid driving licence, without a safety helmet and even with a pillion rider, could not and did not enter into the cause of the collision. The fact of the matter was that on balance of probabilities, the first appellant did not cause or contribute to the cause of the accident. ... She should not have been penalised.

[83] Similarly in our present case, it has not been proven that the lack of registration of the 1st defendant had caused or contributed to the death of the deceased child. Furthermore, it was not proven, nor was any evidence adduced, that knowledge of paediatric care was relevant. The clear and uncontradicted evidence of DW1, which I accepted, was that the child was suffering from a serious and latent illness that could not have been known by the 1st defendant or any doctor in the circumstances and the emergency treatment provided was appropriate. It had not been proven that it would have made any difference to the outcome if the 1st defendant had special paediatric knowledge.

[84] The plaintiffs next said that the 1st defendant administered Voltaren notwithstanding his complete absence of knowledge about its administration and what was more, by injection because

A the clinic lacked suppository. As previously mentioned, it was not proven that the administration of Voltaren either contributed to or caused the death of the deceased child. In fact, the PW4 and DW1 said that there was no evidence of any adverse reaction to the drug. That being the case, it was of no consequence even if
B the 1st defendant did not have the knowledge about the administration of Voltaren or that he had administered it by injection. It is not that I am saying that it was proven that the 1st defendant did not have such knowledge. In truth, the plaintiffs had not adduced evidence or proven that the 1st defendant had
C no knowledge of the administration of Voltaren. Thus, the plaintiffs had not proven a causative link between the administration of Voltaren and the death of the child.

[85] The next set of facts relied on by the plaintiffs pertained to
D the 1st defendant's failure to take the child's blood pressure because the clinic lacked the paediatric cuff. For this to be of any relevance, it was necessary for the plaintiff to lead evidence to prove that taking the child's blood pressure with a paediatric cuff would have made a difference to the outcome or the failure to do
E so caused or contributed to the child's death. There being no such evidence, the attempt by the plaintiffs to prove a causative link in this failed.

[86] I come now to the matter of not calling an ambulance for
F the child. In so far as causation was concerned, it was axiomatic that the plaintiffs proved on balance of probabilities that the calling of an ambulance would have made a difference to the outcome, ie, that the child would not have died. There simply was no evidence adduced to show how, under the circumstances, the
G calling of an ambulance would have prevented the death of the child. What the evidence established was that the mother and child were at the clinic more or less ten minutes. The 1st defendant believed it would be faster for the mother to take the child herself to the hospital rather than wait for an ambulance that
H can take some time to arrive. As mentioned earlier, under the circumstances, that was reasonable. The evidence established that the 2nd defendant took 30 minutes to get to the hospital from the clinic. Further, the child had expired soon after arrival at the entrance of the A & E ward of the hospital, which going by the
I evidence, could only have been just minutes before actual arrival in the ward at 5.40pm. Would the calling of an ambulance have

made the difference in saving this child's life? Whilst it was possible that the calling of the ambulance might have saved his life, it was equally possible that it might not. The onus was on the plaintiffs to establish that the calling of the ambulance might have saved his life. There was no evidence adduced of this and it was not for this court to speculate. That would have been wrong. Edgar Joseph Jr SCJ said as much in *Sundram a/l Ramasay v. Arujunan a/l Arumugam & Anor* [1994] 4 CLJ 300 at p. 310:

> ... there were no objective facts from which it could be inferred, as a matter of reasonable probability that the plaintiff had sustained the head injury as a result of falling to the ground following the prior collision with the other motorcycle. We accept, however, that upon the evidence, it was possible that he had sustained the head injury in that way. It was equally possible that he had not. So there was insufficient evidence to connect the head injury with the other motorcycle. In this context, we are reminded of the words of Suffian FJ (as then was) in *Guan Soon Tin Mining Co v. Wong Fook Kum* [1969] 1 MLJ 99 at p 103 col 2E-F:
>
> > There was no positive proof, as there was in the Grand by case (1923) 87 JP 105; 21 LGR 329 that the discharge from the defendant's mine had anything to do with the death of, the fish; there was only a possibility
>
> With respect, it would therefore be a pure conjecture or a mere guess, to say that the plaintiff's head injury had been caused as a result of his falling to the ground following the prior collision with the other motor cycle. **And, it is axiomatic that the court is not entitled to guess.** (emphasis added)

[87] Similarly, in the present case, the court was not entitled to guess. Hence, I found that the plaintiffs had not established a causative link between the failure to call an ambulance and the death of the child.

[88] On the final point that the 1st defendant should have turned away the mother at the door, the question is whether the 1st defendant's decision to treat the child had caused a delay in getting appropriate and qualified care to the child thereby causing his death. As already determined, the evidence established that time spent at the clinic was ten minutes or less. The plaintiffs, in order to establish causation, needed to prove that arrival at the Johor Specialist Hospital ten minutes sooner would have made the

A difference in saving the child's life. The plaintiffs did not lead evidence on this. There was a possibility it might have made the difference. On the other hand, it was equally possible it might not have and that the child would have died in any event.

B **[89]** This brings to mind the case of *Barnett v. Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428. Three night men went to the casualty department of the defendant's hospital with a complaint that they had been vomiting for three hours after drinking some tea. The doctor in casualty failed to C examine them but instead referred them to their own doctors. They went away but some hours later one of them died from what proved to be arsenic poisoning. The hospital admitted negligence in failing to treat the man properly. His widow's claim under the Fatal Accidents Act nonetheless failed because D causation was not established: the quantity had been so large that probably the deceased would have died in any event, whether or not he had been examined properly and had received appropriate treatment.

E **[90]** What this case illustrates is that since the onus to prove causation was on the plaintiffs, it was vital to call medical evidence to prove the same. In the present case, medical evidence should have been adduced to show that arrival at the Johor Specialist hospital ten minutes earlier would have made the difference in F saving the deceased child's life. Put in another way, it must be established that the delay of ten minutes in arriving at the A & E ward of the Johor Specialist hospital led to the death of the deceased child. Since the evidence on this was not provided, the plaintiffs failed to prove that the ten minutes spent at the clinic G that had ensued from the decision of the 1st defendant not to turn away the mother at the door, was the cause of or contributed to the death of the child.

Conclusion On The Claim In Negligence

H **[91]** For the reasons given above, I could not come to any conclusion that but for the negligence of the defendants, the death of the deceased child would not have occurred. Hence, even if I had been wrong in concluding that the 2nd and 3rd defendants did not owe the plaintiffs any duty of care or that the defendants I had not breached any duty of care if it existed, the plaintiffs' claim in negligence had still to be dismissed because of the failure to prove causation.

The Claim For Breach Of Contract

[92] I found that there was no contract formed between the plaintiffs and the defendants in this case. My reasons for saying so are these.

[93] In the first place, it is well settled that for a contract to exist between parties, there must be consideration. Accordingly, s. 26 of the Contracts Act 1950 provides that a contract without consideration is void unless it comes under one of the exceptions in the section. The exception relevant for our purposes is s. 26(b) *viz*, "a promise to compensate, wholly or in part, a person who has already voluntarily done something for the promisor, or something which the promisor was legally compellable to do." On the facts established by the evidence, I found that at the time the 1st defendant rendered the emergency medical treatment, no consideration was given by the plaintiffs nor was any consideration accepted by the 1st defendant. Consequently, there was no contract formed with the defendants.

[94] Furthermore, the situation that had arisen did not come within any of the exceptions in s. 26 not even s. 26(b). This is because at the time the 1st defendant provided the emergency medical treatment to the deceased, no payment was requested, offered, discussed, promised or made. It is true that the 1st plaintiff made a payment later. However, this was not contemporaneous with the actions of the 1st defendant nor requested by the defendants or promised by either one of the plaintiffs. In my opinion, such payment made in those circumstances did not amount to consideration and did not come within the exception in s. 26(b). In any event, the belated payment of RM20 made on the insistence of the 1st plaintiff who, without the slightest compunction admitted in court he did so because he was seeking for evidence, should be regarded as past consideration which in any case is invalid consideration.

[95] Secondly, from the facts established, there was no intention to create a contractual relationship on the part of the defendants. The evidence clearly showed that the 1st defendant was an attachment student and only intended to respond to the 2nd plaintiff's cry for help in an emergency situation as a good Samaritan. From the evidence of both the 2nd plaintiff and the 1st

defendant, it was clear that payment was neither asked for, nor discussed or made at the time of treatment. Hence, there was never any intention to charge the 2nd plaintiff for the emergency medical treatment provided nor did the defendants ever requested payment. In such circumstances, there could not be, in my opinion, a valid contract formed between the plaintiffs and the 1st defendant.

[96] As for the 2nd and 3rd defendants, the evidence was clear that the 1st defendant did not have authority whether actual or ostensible, to enter into a contract with the plaintiffs on behalf of the 2nd and 3rd defendants. Moreover, at no time was the 1st defendant either actually or held out to be, an agent of the 2nd and 3rd defendants with the authority to treat patients, nor held out to be a registered doctor. In fact, the 1st defendant was standing in front of the counter of the clinic ie, the public area when the 2nd plaintiff arrived and there was no other patient in the clinic. The 1st defendant had also told the 2nd plaintiff that the doctor was out. The 2nd plaintiff admitted she insisted that the 1st defendant treatead the child notwithstanding that she thought the 1st defendant was not a doctor. The 1st defendant also did not have access to the doctor's table and the medical equipment placed thereon. Thus, it was undeniable that the 1st defendant, of his own volition given the circumstances, elected to treat the child. His actions could in no way create liability for the 2nd and 3rd defendants in contract.

[97] In any event, even if it could be said that a contract was formed, it had not been proven that there was any breach of contract or any loss caused to the plaintiffs by the defendants. As already stated, the actions of the 1st defendant when rendering the emergency medical treatment and the procedures that he followed as to examination, diagnosis, and advice did not cause the death of the deceased nor worsen his condition. Furthermore, the non-registration of the 1st defendant did not cause any loss to the plaintiffs as it neither caused the death of the deceased child nor worsen his condition. As for the 2nd and 3rd defendants, they did not breach any contract with the plaintiffs because they did not permit or authorised the 1st defendant to treat patients. Neither did they hold out the 1st defendant as their agent or having such permission or authority.

[98] For these reasons, the plaintiffs failed in their claim in contract.

Conclusion

[99] In the result, the plaintiffs' claim against the defendants had to be dismissed. That I did with costs to the defendants to be taxed unless agreed.